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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-240

ST. PAUL FIRE & MARINE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DAVID M. BARRY, *et al.*, *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

MOTION FOR LEAVE TO FILE AND BRIEF *AMICI CURIAE* OF THE AMERICAN INSURANCE ASSOCIATION, THE ALLIANCE OF AMERICAN INSURERS AND THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

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The American Insurance Association ("AIA"), the Alliance of American Insurers ("Alliance") and the National Association of Independent Insurers ("NAII") move this Court for leave to file the attached brief *amici curiae* in this case.

The movants have previously filed, with the consent of all parties, a brief *amici curiae* in support of the petition for a writ of certiorari. The appropriate con-

sent on behalf of the petitioners to the filing of this brief has been given. The consent of counsel for the respondents was requested but refused.

The AIA is a voluntary trade association of approximately 145 stock insurance companies; the Alliance is a voluntary trade association of approximately 100 mutual insurance companies; and the NAII is a voluntary trade association of over 400 insurance companies.[1] Together, these companies write most of the property and casualty insurance written in the United States.[2] In 1975, the net premiums received by the member companies of the three associations exceeded $45 billion.

The issue in this case—the applicability of the antitrust exemption accorded by the McCarran-Ferguson Act to insurers when sued by those seeking insurance—is of major importance to the membership of the *amici curiae*. The Act expressly renders the Sherman Act inapplicable to those engaged in the "business of insurance" to the extent regulated by state law, except in cases of "boycott, coercion, and intimidation." Until the decision below, the "boycott exception" has been construed to apply only to concerted refusals to deal

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[1] The members of the AIA, the Alliance and the NAII are listed in Appendices A, B and C, respectively, to the previously filed brief *amici curiae* in support of the petition for a writ of certiorari.

[2] Property and casualty insurance protects individuals and commercial enterprises against loss or damage to the insured's property caused by fire, theft, collision and other perils, and against losses arising from the insured's legal liability for injuries to other persons or damage to the property of others. The major lines of property and casualty insurance include automobile liability and physical damage, homeowners' multiple peril, commercial fire, workers' compensation, products liability and medical malpractice liability.

by insurers or insurance agents designed to eliminate other insurers or agents from competition, or to coercively influence their trade practices. The Court of Appeals below, however, has expanded the exception to permit policyholders unable to obtain the insurance coverage they desire to seek treble damage and injunctive relief in the federal courts, even though a state fully regulates the relations between insurers and their insureds.

The effect of the decision below will be to embroil the member companies of the *amici curiae* in the defense of antitrust suits whenever a policyholder dissatisfied with the terms of coverage gains admittance to the federal courts by alleging a concerted denial of the coverage he wants. Contrary to the policy and purpose of the McCarran Act, the decision of the Court of Appeals will thus place AIA, Alliance and NAII member companies in the dilemma of complying with conflicting state regulatory and federal antitrust standards.

Of particular concern to the *amici curiae* is the impact of the decision below on the validity under the antitrust laws of the numerous joint arrangements in the property and casualty insurance industry for the spreading (or "pooling") of risks. These arrangements have been created or authorized by the states to provide insurance for risks too large or unpredictable to be insured by individual companies. One such risk is medical malpractice liability, the subject of this case. Acting upon a proposal of the *amici curiae*, thirty-seven states have now established insurance pools (called Joint Underwriting Associations) composed of property and liability insurers, including the member

companies of the *amici curiae,* to provide coverage to physicians and hospitals.

Under the rationale of the decision below, however, an insurance pool's failure to provide requested coverages to applicants for insurance will not only be characterized as a "boycott" for purposes of removing the McCarran Act exemption, but, indeed, as a "boycott" *per se* illegal under the Sherman Act. The holding below, moreover, would appear to permit *per se* challenges to the joint development by insurers of uniform risk classifications, standardization of policy coverages and the joint collection and analysis of loss data whenever such activities have resulted in rejection of unacceptable risks.

For these reasons, the AIA, the Alliance and the NAII respectfully request leave to file the accompanying brief *amici curiae* in support of a reversal of the decision below.

Respectfully submitted,

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

OPINIONS BELOW 1

INTEREST OF *Amici Curiae* 1

QUESTION PRESENTED 2

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. THE DECISION BELOW WILL JEOPARDIZE THE EXISTENCE OF STATE MANDATED OR REGULATED INSURANCE POOLS NECESSARY TO MAKE INSURANCE AVAILABLE TO HIGH-RISK CONSUMERS 3

A. Under State Direction or Authorization, Insurers Have Acted Vigorously to Provide Insurance in High-Risk Markets, Including the Medical Malpractice Market . 4

B. State-Regulated Insurance Pools Have Also Been Formed to Insure Risks of Unusually Large Magnitude 14

C. The Decision Below Will Permit Insurance Pools to Be Challenged As *Per Se* Unlawful Group Boycotts Despite State Regulatory Oversight 16

D. Joint Pooling of Loss Experience, Uniform Systems for Risk Classification and Use of Standardized Coverages Will Become Vulnerable to Antitrust Attack 20

E. The Doctrine of *Parker* v. *Brown* Would Not Immunize Most Pooling Arrangements and Practices Regulated by the States 24

II. REMOVAL OF THE ANTITRUST EXEMPTION FROM POLICYHOLDER SUITS WILL PLACE INSURERS IN THE DILEMMA OF COMPLYING WITH CONFLICTING STATE AND FEDERAL STANDARDS 26

III. CONSISTENT WITH THE POLICY OF DEFERENCE TO STATE REGULATION OF THE INSURER-INSURED RELATIONSHIP, CONGRESS INTENDED THE TERM "BOYCOTT" TO APPLY ONLY TO REFUSALS TO DEAL AMONG COMPETING INSURERS OR AGENTS 28

CONCLUSION 35

CASES: Page

American Column and Lumber Co. v. *United States*, 257 U.S. 377 (1921) 22

Barry v. *St. Paul Fire & Marine Insurance Co.*, 555 F.2d 3 (1st Cir. 1977) .....*passim*

Cantor v. *Detroit Edison Co.*, 428 U.S. 579 (1976) ... 24

Duke Power Co. v. *Carolina Environmental Study Group*, No. 77-262, *prob. juris. noted*, Nov. 7, 1977 15

Eastern States Retail Lumber Dealers' Association v. *United States*, 234 U.S. 600 (1914) 22

Fashion Originators' Guild of America, Inc. v. *FTC*, 312 U.S. 457 (1941) 17

FTC v. *National Casualty Co.*, 357 U.S. 560 (1958) .. 25

Kiefer-Stewart Co. v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951) 19

Klor's, Inc. v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959) 17

Meicler v. *Aetna Casualty and Surety Co.*, 506 F.2d 732 (5th Cir. 1975) 21

Norfolk Monument Co., Inc. v. *Woodlawn Memorial Gardens, Inc.*, 394 U.S. 700 (1969) 22

Northern California Pharmaceutical Association v. *United States*, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962) 22

Nuclear Regulatory Commission v. *Carolina Environmental Study Group*, No. 77-262, *prob. juris. noted*, Nov. 7, 1977 15

Ohio AFL-CIO v. *Insurance Rating Board*, 451 F.2d 1178 (6th Cir. 1971) 25

Parker v. *Brown*, 317 U.S. 341 (1943) 24, 25, 26

Plymouth Dealers Association of Northern California v. *United States*, 279 F.2d 128 (9th Cir. 1960) 22

Radiant Burners, Inc. v. *Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1961) 17

SEC v. *National Securities, Inc.*, 393 U.S. 453 (1969) 4, 35

Theatre Enterprises, Inc. v. *Paramount Film Distributing Corp.*, 346 U.S. 537 (1954) 22

Page

United States v. *Baton Rouge Insurance Exchange*, 1958 CCH Trade Cas. ¶ 69,068 (E.D. La. 1958) ... 31

United States v. *Cincinnati Insurance Board*, 1963 CCH Trade Cas. ¶ 70,945 (S.D. Ohio 1963) 31

United States v. *General Motors Corp.*, 384 U.S. 127 (1966) 17

United States v. *Insurance Board of Cleveland*, 144 F. Supp. 685 (N.D. Ohio 1956), 188 F. Supp. 949 (N.D. Ohio 1960) 31

United States v. *Nationwide Trailer Rental System, Inc.*, 156 F. Supp. 800 (D. Kan.), *aff'd per curiam*, 355 U.S. 10 (1957) 22

United States v. *New Orleans Insurance Exchange*, 148 F. Supp. 915 (E.D. La.), *aff'd per curiam*, 355 U.S. 22 (1957) 31

United States v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944) .....24, 28, 29, *passim*

United States v. *Yellow Cab Co.*, 332 U.S. 218 (1947) .. 19

STATUTES:

Conn. Gen. Stat. § 38-110 (1958) 15

McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1013 (1970) *passim*

N. Y. Insur. Law § 47 (McKinney 1966) 15

N. Y. Insur. Law § 316 (g) (McKinney Supp. 1977).. 9

N. Y. Insur. Law §§ 681-695 (McKinney Supp. 1977). 9

Price-Anderson Act, 42 U.S.C. § 2210 (1970) 15

Sherman Act, 15 U.S.C. § 1 (Supp. 1975) .....*passim*

Urban Property Protection and Reinsurance Act of 1968, 12 U.S.C. § 1749 bbb *et seq.* (1970) 12

LEGISLATIVE MATERIALS:

Joint Hearing on S. 1362, H.R. 3269 and H.R. 3270 Before the Subcommittees of the Committees on the Judiciary, 78th Cong., 1st Sess. (1943-44) 33

H.R. Rep. No. 873, 78th Cong., 1st Sess. (1943) 24-25

Page

H.R. Rep. No. 143, 79th Cong., 1st Sess. (1945) 29
S. 340, 79th Cong., 1st Sess. (1945) 29
S. Rep. No. 1112, 78th Cong., 2d Sess. (1944) 25, 32
90 Cong. Rec. 6532 (1944) 35
91 Cong. Rec. 1087-88 (1945) 34, 35
91 Cong. Rec. 1094 (1945) 33
91 Cong. Rec. 1480 (1945) 34
91 Cong. Rec. 1483 (1945) 34
91 Cong. Rec. 1485 (1945) 32, 34
91 Cong. Rec. 1486 (1945) 32

OTHER MATERIALS:

Brief of Appellant United States in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944) 24, 30

Economic Regulation of Insurance in the United States, U.S. Department of Transportation, Automobile Insurance and Compensation Study (June 1970) 27, 35-36

Meeting the Insurance Crisis of Our Cities, National Advisory Panel on Insurance in Riot-Affected Areas (January 1968) 12

Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business, Hanson, Dineen and Johnson (1974) 16

The Pricing and Marketing of Insurance, Report of the U.S. Department of Justice to the Task Group on Antitrust Immunities (January 1977) 9, 23

The Problems of Insuring Medical Malpractice, All-Industry Medical Malpractice Insurance Committee (November 1975) 7, 8, 9

Proceedings of the NAIC (1947) 16

1 *Proceedings of the NAIC* (1973) 16

Report of the Special Advisory Commission on Medical Malpractice of the State of New York (January 1976) 8

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BRIEF *AMICI CURIAE* OF THE AMERICAN INSURANCE ASSOCIATION, THE ALLIANCE OF AMERICAN INSURERS AND THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

OPINIONS BELOW

The opinion of the United States District Court for the District of Rhode Island is not reported. The majority and dissenting opinions of the Court of Appeals are reported at 555 F.2d 3.

INTEREST OF *AMICI CURIAE*

The interest of the American Insurance Association ("AIA"), the Alliance of American Insurers ("Alliance") and the National Association of Independent Insurers ("NAII") is set forth in the accompanying Motion for Leave to File Brief *Amici Curiae*.

QUESTION PRESENTED

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1013 (1970) ("McCarran Act") provides that the federal antitrust laws are not applicable to the "business of insurance" when regulated by state law, except in cases of "boycott, coercion, and intimidation." The question presented is whether the "boycott exception" extends to concerted refusals by insurers to provide policyholders with the insurance coverage they demand on terms they deem satisfactory, notwithstanding state regulation of the availability and scope of such coverage.

INTRODUCTION AND SUMMARY OF ARGUMENT

In a two-to-one decision, the Court of Appeals for the First Circuit held that the McCarran Act did not bar a federal antitrust class action suit by Rhode Island physicians who contended that their inability to obtain medical malpractice insurance on the terms and rates they desired was the result of an insurance company conspiracy. Despite Rhode Island's regulation of the availability and price of malpractice coverage, the majority below ruled that suit was permissible under the McCarran Act's "boycott exception" because of respondents' allegations characterizing the alleged conspiracy as a concerted refusal to deal.

The court in effect construed the term "boycott" to include agreements by insurers to fix the terms and coverage of insurance or to refrain from competing for each other's customers. The decision below thereby jeopardizes the existence of joint risk-sharing arrangements created by property and casualty insurers and regulated by the states for the purpose of providing insurance to high-risk consumers who might not otherwise be able to obtain coverage. Under the novel interpretation of "boycott" advanced by the court of appeals, participants in such joint endeavors which refuse to sell coverages requested by policyholders would be deprived of the antitrust exemption expressly conferred by Congress and subjected to the application of the *per se* test of illegality applied to group boycotts.

This result abrogates the intent of Congress that the "boycott exception" apply only to blacklisting and other exclusionary practices by insurers directed at other members of the industry. It is also contrary to the policy and purpose of the McCarran Act—federal deference to state regulation of the relationship between insurers and their policyholders. Insurers participating in pooling activities will now be placed in the untenable position of attempting to comply with state regulatory requirements while also meeting federal antitrust standards applied in suits brought by disgruntled policyholders.

To effectuate the intent of Congress that joint activities by insurers be immune from the antitrust laws when they directly relate to the relationship with insureds and are regulated by the states, the court of appeals' interpretation of the boycott exception should be rejected.

ARGUMENT

I. THE DECISION BELOW WILL JEOPARDIZE THE EXISTENCE OF STATE MANDATED OR REGULATED INSURANCE POOLS NECESSARY TO MAKE INSURANCE AVAILABLE TO HIGH-RISK CONSUMERS

The intent of the McCarran Act was to suspend the application of the federal antitrust laws in deference

to state regulation of the "relationship between insurer and insured," including the "type of policy which could be issued." *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969). This central purpose of the McCarran Act is subverted by the decision below, which (1) defines as a "boycott" any joint refusal to provide insurance on the terms demanded, and (2) thus permits policyholders to take their grievances to federal court despite state regulation of the substance of their complaints. The court of appeals' distorted construction of the boycott exception thus brings into question the validity under the antitrust laws of all forms of joint insurer activity designed to make insurance available in high risk markets.

A. Under State Direction Or Authorization, Insurers Have Acted Vigorously To Provide Insurance In High-Risk Markets, Including The Medical Malpractice Market

In contrast to the sale of other products or services, an insurer's profitability depends not only on the prices it charges or the quality of its products or services, but also on the nature of the customers it selects. The process of selection is called underwriting, a process through which the insurer classifies risks based on analysis of historical loss data and projected trends, and then decides which risks it can safely insure.[1] Certain

[1] There is no doubt that underwriting is the "business of insurance" within the meaning of the McCarran Act. In SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969), this Court included within the "business of insurance" the "type of policy which could be issued," "its reliability," the "fixing of rates," the "selling . . . of policies" and "other activities of insurance companies [which] relate . . . closely to their status as reliable insurers . . . ." Underwriting is not only inseparable from the selling of insurance policies, the setting of rates and the determination of the coverages provided, but is also an important means of maintaining solvency and reliability through proper selection of risks.

risks will inevitably be considered undesirable to individual underwriters because the expected losses exceed permissible rates, are beyond the insurer's financial capacity or fail to meet the underwriter's standards. The medical malpractice insurance which is the subject of this case is an example of a "residual" or "involuntary" market—one in which many insureds cannot obtain insurance from individual companies because they are unacceptable risks.

Assured availability of insurance to consumers at a price which is not excessive or unfairly discriminatory is a major goal of state insurance regulation. One response of the states to problems of availability has been to require (or, in some cases, authorize) property and casualty insurers to participate in joint endeavors to provide insurance for risks—such as medical malpractice liability—which the voluntary market finds unacceptable. These shared market mechanisms are designed to distribute equitably among insurers the losses which are anticipated from risks which cannot be placed in the voluntary market. Two basic forms of joint ventures have been adopted to deal with residual market problems:

> *Joint Underwriting Associations:* The state establishes or authorizes a separate facility, composed of all insurers licensed to write the particular line. Business is written through the pool and all losses are shared by members of the pool. The facility can have its own staff and operate as a separate insurer or it can utilize one or more servicing carriers.
>
> *Reinsurance Pools:* Insurers are required or authorized to "take all comers," but may decide whether to retain the risk or cede it to a reinsur-

ance facility composed of all insurers licensed to write the particular line.[2]

The response of insurers and the states to the "crisis" in medical malpractice insurance and problems in other involuntary markets demonstrates the extensive use of these joint venture arrangements and the depth of state regulation of them.

1. Medical Malpractice Insurance

Medical malpractice insurance was the first liability line of insurance in which the states instituted a mandatory shared market mechanism and is still probably the most acute involuntary market problem.

The availability of medical malpractice insurance assumed crisis proportions in 1974, when the insurance carrier which had provided coverage for the members of the New York Medical Society for over twenty-four years indicated that it would not renew its coverage. The problem spread when insurers in other states began to withdraw from the market, or raised premiums to levels which physicians and hospitals contended they could not afford.

[2] A third method of underwriting involuntary market risks is the assigned risk plan, in which risks are assigned to individual insurers on the basis of the number of similar risks insured in the voluntary market. A fourth, little-used, method is the state fund, which may be subsidized by private insurers to cover deficits. As an example, Maryland replaced its automobile assigned risk plan in 1973 with a state fund which is restricted to business where there is evidence of cancellation from one insurer or rejection by two insurers.

The exponential rate of increase in premium levels[3] was directly attributable to drastic increases in the number of claims and the dollar amounts of malpractice settlements. This acceleration in the size and frequency of claims resulted from the interaction of several factors, principal among which are: (1) rapid inflation in the cost of health care services; (2) marked increases in the utilization of health care services resulting from expanded private and governmental health insurance (*e.g.,* Medicare and Medicaid); (3) the high risk of injury associated with more sophisticated and advanced medical procedures and technology; (4) changes in the traditional doctor-patient relationship reflecting the impersonal character of more organized and specialty-oriented health care delivery systems; (5) recent developments in negligence law relaxing the standards for recovery; (6) the effects of inflation on juries' awards; and (7) an increasingly litigious public whose only redress for medical injury is the health care providers' liability insurance.

Past patterns of claims experience were inadequate to predict these developments, a problem compounded by the abnormally long period of time between issu-

[3] From 1965 through 1974, medical malpractice insurance rates for physicians increased five-fold. By mid-1975, rate levels for physicians and surgeons professional liability insurance in some states were more than 100 percent higher than 1974 levels. ***The Problems of Insuring Medical Malpractice,*** All-Industry Medical Malpractice Insurance Committee, November 1975, at 2. The referenced publication summarizes a special study of 10,000 medical malpractice claim files conducted by the Insurance Services Office (ISO) on behalf of ***amici curiae*** AIA and the Alliance and reviewed by the All-Industry Committee on Medical Malpractice Insurance (hereinafter "All-Industry Study"). For the convenience of the Court, a copy of the summary of the All-Industry Study has been lodged with the Clerk.

ance of policies and reporting of claims. Under the traditional type of policy, written on an "occurrence" basis, the physician is insured for any claim that might arise at any time in the future as the result of an incident that occurred during the twelve months the policy is in force. Consequently, it may be years before all medical "injuries" occurring in the policy year become reported claims, a claims phenomenon frequently referred to as the "long tail" factor.[4]

The result has been that total losses have far outstripped premiums.[5] Insurers today have therefore gen-

[4] In its January 1973 report, the Medical Malpractice Commission established by the Secretary of Health, Education and Welfare found that on the average only half of all claims are closed within 18 months after the incident occurred and 10 percent still remain open after six and one-half years. A study by the California Insurance Department determined that only 38 percent of all claims are reported within two years of the beginning of the policy year, and that only 33 percent of the ultimate losses, in terms of dollars paid out, are paid within five years after the beginning of the policy year. Yet a third study by the Insurance Service Office (ISO) has found that 75 months after the beginning of the policy year, fewer than 70 percent of the total incurred losses are paid. *See All-Industry Study*, at 9. In short, a significant portion of claims are not reported until years after the policy year ends, and the claims presented later tend to be higher in terms of dollars than those reported more quickly.

[5] A study conducted by the California Joint Legislative Audit Committee concluded that malpractice insurers in California had undergone serious erosion in their financial condition in recent years, despite premium rates that were the highest in the nation. As a group, malpractice insurers were found to show an underwriting loss. *See Report of the Special Advisory Commission on Medical Malpractice of the State of New York*, January 1976, at 222. The All-Industry Study found that ten years after the close of policy year 1966, the total of losses and loss adjustment expenses on *known* incidents during that year exceeded premiums by $6.7 million, and that the ultimate settlement of all claims was still uncertain. *All-Industry Study*, at 5-7.

erally been unwilling to accept the tremendously high risk associated with this type of coverage.[6]

Some malpractice insurers, rather than withdrawing from the market, elected to sell only "claims-made" policies. "Claims-made" coverage applies only to claims actually submitted in the given policy year, regardless of when the alleged malpractice occurred. Although the total amount of payments is not likely to be reduced under a "claims-made" approach, the premium can be made more relevant to current conditions. However, the medical profession has been reluctant to accept these policies because of the physicians' desire for continued protection once their active practice has terminated.

New York was the first state to react to the increasing unavailability of malpractice coverage. Adopting a proposal offered by the *amici curiae*, its legislature enacted a law creating an involuntary Joint Underwriting Association (JUA) whose membership consisted of all liability insurers doing business in that state. N.Y. Insur. Law §§ 681-695 (McKinney Supp. 1977). The temporary JUA was to remain in existence until the formulation and implementation of a tort reform program.[7]

[6] While there was considerable competition among insurers in the 1960's to insure doctors, fewer than a dozen companies voluntarily provide a significant market for this coverage today. *All-Industry Study*, at 2. A Department of Justice study suggests that there are generally "few companies writing [medical malpractice insurance] in any area" because of the " 'long-tail' factor" and state rate regulation. *The Pricing and Marketing of Insurance*, Report of the U.S. Department of Justice to the Task Group on Antitrust Immunities, January 1977, at 283.

[7] New York also authorized the formation of a hospital mutual insurance company to provide what was essentially a self-insurance facility. N.Y. Insur. Law § 316(g) (McKinney Supp. 1977).

Following New York's example, thirty-seven states now have laws authorizing JUAs which become operative upon a finding by the state insurance commissioner that malpractice insurance is not available in the voluntary market.[8] In almost all of the JUAs, membership is compulsory for all property and casualty insurers. In sixteen states, JUAs have actually become operative. In addition, twelve states have authorized creation of medical mutual companies, often in conjunction with a JUA. In two states, workers' compensation funds were empowered to extend coverage for medical malpractice. Ten states have formed Patient Compensation Funds for the payment of judgments out of a special state fund when the judgment exceeds certain limits. Most states have imposed extensive reporting requirements on insurers to monitor the problems of availability and obtain information for legislative changes.[9]

Thus, in less than three years, over two-thirds of the states have affirmatively acted to assure the availability of malpractice insurance to physicians and hospitals, most often in the form of joint insurer underwriting.

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[8] As the Court of Appeals noted, Rhode Island was one of the states which formed a JUA to provide medical malpractice insurance. 555 F.2d at 5-6, n.2.

[9] In addition to expanded state regulatory activities in the insurance field, numerous states instituted reforms in tort law and other legal provisions pertaining to malpractice. Typical changes included statutory alteration of the standard of due care, shortening of statutes of limitation, elimination of the *ad damnum* clause in malpractice complaints, authorization of binding arbitration, limitations on liability in cases of informed consent, statutory limits on liability, limitations on attorneys' fees, and creation of peer review panels to investigate instances of malpractice and improve health care quality standards.

2. Other Lines of Insurance

The states have similarly mandated joint venture arrangements to deal with availability problems in most of the other major lines of property and casualty insurance.

a. *Automobile:* Beginning in the 1920's and 1930's, the states began enacting auomobile financial responsibility laws, requiring motorists involved in accidents to carry proof of financial responsibility for future accidents, and compulsory automobile insurance laws. As a result, motorists were required to purchase automobile liability insurance. Many of them represented unacceptable risks because of their driving records or other factors. Consequently, the states have enacted assigned risk plans almost coincidentally with the passage of financial responsibility or compulsory liability laws, and, by 1959, every state and the District of Columbia had such a plan.

Seven states later opted for alternative shared market mechanisms; three (Florida, Hawaii and Missouri) for mandatory joint underwriting associations, and four (Massachusetts, North Carolina, South Carolina and New Hampshire) for reinsurance facilities.

b. *Property:* The involuntary property insurance market is of more recent origin. For some time before 1967, inflation, urban decay and the growing incidence of crime in urban areas had restricted the availability of many forms of property insurance for dwellings and commercial structures. In 1967, following widespread rioting in urban areas, President Johnson appointed the National Advisory Commission on Civil Disorders. To deal specifically with the insurance problems of urban core residents and businessmen, the

Commission appointed the National Advisory Panel on Insurance in Riot-Affected Areas (the "Hughes Panel"). The report of the Hughes Panel [10] resulted in the enactment by Congress of the Urban Property Protection and Reinsurance Act of 1968, 12 U.S.C. § 1749bbb *et seq.* (1970). The Act's solution to the urban property insurance availability problem was to provide federal riot reinsurance. Reinsurance was conditioned on the existence of state Fair Access to Insurance Requirements ("FAIR") Plans "to make essential property insurance more readily available in, but not necessarily limited to, urban areas." 12 U.S.C. § 1749bbb-3(b). The plan "must be approved by, and administered under the supervision of, the State insurance authority, or be authorized or required by State law." *Id.* In recognition of the states' primary role in regulating insurance availability, federal measures were designed to support rather than supplant local efforts.

Twenty-six states and the District of Columbia now have FAIR Plans. Three are voluntary, while the others require all insurers to participate in Plan writings and losses as a condition of writing property insurance in the state. Most state enabling laws prescribe Plan coverages.[11]

c. *Workers' Compensation:* All states now have workers' compensation legislation requiring defined

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[10] *Meeting the Insurance Crisis of Our Cities,* National Advisory Panel on Insurance in Riot-Affected Areas, January 1968.

[11] Seven states, subject to recurrent hurricane damage, now have "Beach Plans" or "Windstorm Pools." In all but one of these states, insurer participation is required based upon its share of the voluntary market for lines available through the plan.

categories of employers to provide medical, disability and rehabilitation benefits to employees for occupational injuries or disease, usually without regard to the fault of the employer. In thirty-two states, legislatures have required or authorized private carriers to provide coverage through statutory assigned risk pools or voluntary pools.

d. *General Liability:* Ever broadening rules of liability constitute heavy financial hazards for many professionals, businesses and governmental entities. As with physicians and hospitals, insurance against liability hazards may be essential to these persons' ability to provide goods and services to the public.

In the area of product liability insurance, the doctrine of strict liability has become widely accepted by courts throughout the country, causing an escalation of claims and losses especially with regard to the machine tool, pharmaceutical and chemical industries. To meet complaints of unavailability, a special committee of *amicus curiae* AIA advocated the adoption of Market Availability Plans ("MAPs") in states where problems had developed. To date, MAPs are operational in eighteen states. The plans are voluntary, instituted by state insurance commissioners in cooperation with the industry. A typical MAP has an Underwriting Committee which develops detailed information on the risks of the insureds and endeavors to obtain coverage from companies which in their judgment are most likely to provide it for the risk in question.

The most recent developing problem area is that of liability insurance for governmental entities, especially municipalities. Erosion of the doctrine of sovereign immunity and voluntary waiver of such immunity have

resulted in problems of market availability, and in a few states MAP-type plans, participation in which is voluntary, have now been created.

Another emerging problem is that of lawyers' malpractice insurance. At least one state has enacted legislation creating a standby JUA for this type of coverage, similar to the JUAs in the medical malpractice area.

In sum, virtually every problem of the availability of property and liability insurance is being dealt with by the states with close insurer cooperation. While insurer participation in these shared market mechanisms usually is mandatory, the procedures for handling this business (such as rate-making, determination of policy forms and coverages and guidelines for cancellation or renewal) are not state-made in the sense of being established by the insurance commissioner. Rather, the procedures are developed by the companies, and are made effective after review and approval by the insurance commissioner.

B. State-Regulated Insurance Pools Have Also Been Formed To Insure Risks Of Unusually Large Magnitude

In addition to the pooling mechanisms created or authorized by the states to deal with involuntary market problems, the insurance industry is characterized by a variety of other risk-sharing arrangements which function, on a permanent or *ad hoc* basis, to provide insurance coverage for specific types of risks too large to be safely handled by individual insurers.

In the permanent pools, insurers share premiums and losses concerning one or more specified insurance coverages. Permanent pools are most often formed to provide underwriting capacity for categories of risks which a single company (even with reinsurance ar-

rangements) could not insure either because of statutory limitations [12] or because of an underwriting judgment that the exposure to possibly catastrophic losses is too great.[13] The pools underwrite policies covering such hazards as those relating to nuclear reactors,[14] ocean shipping, processing of negative films for motion pictures, railroad rolling stock, oil refineries, grain elevators and aviation. Permanent pools are generally managed by a full-time professional staff providing specialized services and expertise.

On a more frequent basis, insurers participate in *ad hoc* pooling arrangements. These voluntary joint ventures are formed for the purpose of underwriting a specific risk, often a large commercial risk, against fire and allied perils or other hazards. Reinsurance is one type of *ad hoc* pooling arrangement, differing from other types in that the contract is not between the insured and the insurance pool but rather between the primary insurers (the "ceding companies") and the reinsurers. In effect, the participants in each of these various *ad hoc* arrangements decide in concert whether to provide insurance and what coverages to afford.

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[12] Typically, states limit the size of any single insured risk to ten percent of a company's paid-up capital and surplus. *See, e.g.*, Conn. Gen. Stat. § 38-110 (1958); N.Y. Insur. Law § 47 (McKinney 1966).

[13] Another reason for the creation of voluntary pools is to provide specialized inspection, loss prevention or claims adjustment services that individual member companies could not economically provide on their own.

[14] Now pending before this Court are consolidated cases involving the constitutionality of the Price-Anderson Act, 42 U.S.C. § 2210 (1970), which limits the total liability arising from nuclear reactor accidents. Duke Power Co. v. Carolina Environmental Study Group, No. 77-262, and Nuclear Regulatory Comm'n v. Carolina Environmental Study Group, No. 77-375, *prob. juris. noted*, November 7, 1977.

Almost all voluntary pooling arrangements, whether permanent or *ad hoc,* are regulated by the states through licensing or other authorization for joint underwriting, review of rules for admission to membership, requirements for the filing of annual and periodic reports and state inspection. As are all property and casualty insurers, the pools are subject to state unfair trade practices acts.[15]

C. The Decision Below Will Permit Insurance Pools To Be Challenged As *Per Se* Unlawful Group Boycotts Despite State Regulatory Oversight

By the very nature of the pooling mechanism, insurers must jointly decide on both the selection of the risks to be insured and the amounts or types of coverages to be provided. A pool's decision not to accede to a prospective insured's request for coverage, or its decision to cancel or not to renew a policy, would thus be indistinguishable from the alleged conduct of petitioners characterized by the court below as a "concerted refusal to deal" and hence a "boycott" necessitating removal of the McCarran Act exemption. The court's misconception of the term "boycott," however, would not be limited to application of the McCarran Act's boycott proviso, but would be extended to subse-

[15] In response to the McCarran Act, all fifty states and the District of Columbia have enacted such legislation, usually patterned on the model Unfair Trade Practices Act approved by the National Association of Insurance Commissioners in 1947 and revised in 1971. *Proceedings of the NAIC* 392, 413 (1947); 1 *Proceedings of the NAIC* 493 (1973). *See also* 1 Hanson, Dineen and Johnson, *Monitoring Competition: A Means Of Regulating The Property and Liability Insurance Business,* at 221 (1974). State insurance commissioners are empowered to issue cease and desist orders directed at certain enumerated practices. They may also define other "unfair methods of competition" or "unfair or deceptive acts or practices" and investigate and proscribe such conduct.

quent application of Sherman Act standards. It is clear that the court's construction of the term was premised upon the view that "boycott" under the McCarran Act and "boycott" under the antitrust laws were congruent terms both of which include any " 'concerted refusal to deal' with a disfavored purchaser" except upon the terms set by the agreeing parties. 555 F.2d at 7-8. Accordingly, conduct which is denominated a "boycott" for purposes of the McCarran Act would automatically be considered a "boycott" for purposes of the Sherman Act. The inevitable logic of the decision below is therefore that a pool's decision to refuse coverage is not only subject to the Sherman Act even though pool activities are regulated by the states, but is *per se* unlawful under the unvarying rule applied to group boycotts as announced in the decisions of this Court.[16]

The *per se* rule of illegality forecloses defenses based on affirmative economic justification or lack of unreasonable restraint on competition.[17] Consequently, pool

[16] *See, e.g.,* United States v. General Motors Corp., 384 U.S. 127 (1966); Radiant Burners, Inc. v. Peoples Gas Light & Coke Co., 364 U.S. 656 (1961); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959). The *Klor's* case is cited by the court of appeals in support of its interpretation of "boycott" as used in the McCarran Act. 555 F.2d at 7.

[17] In Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. at 211, group boycotts were characterized as within that category of restraints on trade which by their " 'nature or character' were unduly restrictive." Examination of public injury, effect on prices or supply or reasonableness under the circumstances was thus irrelevant. *See also* United States v. General Motors, Inc., 384 U.S. at 146, where the *per se* rule was applied to prohibit inquiry "into the economic motivation underlying [the alleged refusal to deal]," and Fashion Originators' Guild of America, Inc. v. FTC, 312 U.S. 457, 467-68 (1941), where the Court upheld the Federal Trade Commission's refusal to receive evidence in support of the contention that a refusal to deal was necessary to combat allegedly tortious acts directed at the defendants.

members could not interpose in their defense the economic need for joint risk-sharing to safeguard against insolvencies arising from catastrophic losses or other unacceptable risks. Nor could pools be justified as increasing the availability of insurance in instances where individual companies did not have the capacity to absorb the potential liability. Likewise, pools could not be defended as procompetitive devices permitting participation in insurance placements by small or medium size insurers whose capacities would not be sufficient to enable them to compete on an individual footing. More importantly, pool members could not justify the rejection of individual risks as too hazardous, or because of insufficient pool capacity, or for any of a multitude of other sound business reasons for declining to provide coverage.

There is considerable potential for such harsh application of the *per se* rules to pools and other risk-sharing ararngements. While it is widely accepted in theory that higher risks should generally be charged higher premiums, where basic insurance coverages are required by state law or otherwise felt to be a necessity, state regulators have not permitted rates sufficient to cover losses. Unless adequate rates are secured, the only alternative for insurers is to restrict the lines of business they will write. If the decision below stands, however, withdrawal from a market may result in antitrust class actions based on boycott theories, exactly the course of action taken by respondents.

It is also not difficult to conceive of "boycott" suits being brought by, for example, an extra-hazardous commercial concern (*e.g.,* an oil refinery) or a potentially catastrophic risk (*e.g.,* a nuclear reactor) upon a pool's refusal to provide coverage because of a dispute over

inadequate safety measures. In the field of automobile insurance, many insurers have subsidiaries or affiliates which sell only to "substandard risks," drivers with bad records who are unable to obtain adequate coverage at the rates approved for better risks. If the preferred risk insurer refuses to insure except through the high risk affiliate, it could be considered a boycott by separately incorporated companies or a "coercive" allocation of customers.[18] The entire business of reinsurance will be placed in jeopardy if prospective policyholders are permitted to sue prime insurers which have refused coverage because of their inability to obtain reinsurance.

Another effect of the court of appeals' decision will be to deprive insurer pools of their ability to adjust the cost of their products in response to market forces. Every limitation of coverage, every exclusion from coverage and, indeed, the risk selectivity of underwriting is aimed at keeping the cost of insurance within the reach of the public. To subject insurance cost-cutting techniques permitted by the states to boycott actions will seriously retard the efforts of insurers to hold costs down.

More significantly, the decision below will adversely affect insurer solvency. It will result in forcing insurers to provide coverage to high risks while simultaneously denying full utilization of the joint mechanisms necessary to disperse losses and prevent insolvency.

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[18] In Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., 340 U.S. 211, 215 (1951), common ownership of separate corporations did not bar a finding of unlawful agreement under the Sherman Act. *See also* United States v. Yellow Cab Co., 332 U.S. 218, 227 (1947), where the Court declared that "the corporate interrelationships of the conspirators . . . are not determinative of the applicability of the Sherman Act."

In sum, the blanket application of the court of appeals' definition of "boycott" could substantially deter continued state-regulated cooperation among insurers to provide insurance to those whose needs could not otherwise be met.

D. Joint Pooling Of Loss Experience, Uniform Systems For Risk Classification And Use Of Standardized Coverages Will Become Vulnerable to Antitrust Attack

The boycott standard originated by the Court of Appeals may also result in the application of the *per se* illegality rule whenever unacceptable risks are denied insurance on the basis of uniform risk classifications. The disruptive impact of the application of a strict liability rule to a function central to the rate-making process is an unintended but very real implication of the decision.

Both the selection of the risks which can safely or profitably be insured (the underwriting process) and the determination of an appropriate price (the rate-making process) depend on accurate assessment of risks. For the major lines of property and casualty insurance, risk assessment involves a projection of expected losses based on the experience of a class of individuals with similar risk characteristics. The degree of accuracy in projection depends primarily on the accumulation of a large pool of statistics relating to loss experience. Insurers have thus found it necessary jointly to collect and analyze their loss data.

In most states, this task is undertaken by licensed rating bureaus or statistical organizations—associations usually formed and managed by the insurer users

of the statistical data.[19] In analyzing historical data, the bureaus and statistical organizations use standard risk classifications, that is, defined classes of insureds which earlier data has shown to display similar risk characteristics. The uniform risk classifications are necessary to assure the reliability and comparability of reported data necessary for determination of rates; they also used in the individual underwriter's selection of the risks it judges acceptable. Virtually all states prohibit unfair discrimination in risk classification and many require prior approval of classifications or validation of the statistical data from which classes are defined.

Nevertheless, under the court of appeals' expansive reading of the "boycott" exception, a prospective policyholder, unable to obtain the coverage desired because a bureau or a statistical organization classified him as a substandard or unacceptable risk, could maintain an antitrust action alleging that the use of the classification constituted a concerted refusal to deal.[20] An "agreement" to boycott could be inferred from: (1) parallel refusals of insurers to furnish coverage

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[19] Some statistical organizations are, however, independently owned and operated. Except in a few "mandatory bureau" states, bureau membership (including participation in the bureau's statistical-gathering plan) is voluntary. Most jurisdictions nonetheless require insurers, whether or not bureau members, to report underwriting results either to the state or to a licensed statistical organization. Insurance pools for special risks (*e.g.*, the nuclear liability and aviation pools) will normally collect and analyze their own loss experience and classify the risks they insure.

[20] *Cf.* Meicler v. Aetna Casualty and Surety Co., 506 F.2d 732 (5th Cir. 1975), where the plaintiff alleged that use of a driver risk classification plan and corresponding rate schedule based on driving records was a "boycott" implemented to enforce "fixed" rates.

for a particular class of unacceptable risks, coupled with (2) knowledge that other insurers had decided similarly and either (3) common membership in the rate bureau or statistical organization which had developed the risk classifications or (4) common use of the classification.[21] An "agreement" could be inferred

[21] While conscious parallel behavior alone is insufficient circumstantial evidence from which a jury would be permitted to infer agreement, Theatre Enterprises, Inc. v. Paramount Film Distributing Corp., 346 U.S. 537, 541 (1954), the addition of some element of explicitly joint or interdependent behavior—such as bureau membership or use of uniform risk classifications in reporting loss data—may enable the question of agreement to reach the jury. *Cf.* Norfolk Monument Co., Inc. v. Woodlawn Memorial Gardens, Inc., 394 U.S. 700 (1969), where the Court summarily reversed summary judgment in favor of defendants because uniform product and practice standards were sufficient evidence from which conspiracy could have been inferred. Alternatively, the circulation by a bureau to its members of risk classifications bearing upon *future* selection of insureds could be viewed as the necessary additional evidence of joint rather than independent behavior. In Eastern States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600 (1914), for example, a retailers' association circulated to its members lists of wholesale dealers who sold at retail. Because the circulation of condemnatory lists had an inherently coercive effect, the Court saw this as simply an attempt to encourage retail dealers to boycott the offending wholesalers. The courts have also prohibited trade associations from circulating "suggested" price lists because of their potential for concerted use in pricing decisions even though there is no express agreement to adhere to the prices. *See, e.g.,* American Column and Lumber Co. v. United States, 257 U.S. 377 (1921); Northern California Pharmaceutical Ass'n v. United States, 306 F.2d 379 (9th Cir.), *cert. denied,* 371 U.S. 862 (1962); Plymouth Dealers Ass'n of Northern California v. United States, 279 F.2d 128 (9th Cir. 1960); United States v. Nationwide Trailer Rental System, Inc., 156 F. Supp. 800 (D. Kan.), *aff'd per curiam,* 355 U.S. 10 (1957). Based on this line of cases, the Department of Justice has concluded that, in the absence of the McCarran Act, the circulation of advisory rates by a bureau would violate § 1 of the Sherman Act even where the bureau's staff had been delegated

even where classifications are established by an independent statistical organization (rather than a bureau) if the classifications are based on data-gathering plans implemented with the assistance of insurers. Indeed, the Department of Justice is of the opinion that, without McCarren Act immunity, "[c]ooperation among the purchasers of trended loss information, such as assisting the [statistical] oranization in the development of a statistical plan, could be construed as sufficient to constitute a combination within the meaning of Section 1 [of the Sherman Act]." *The Pricing and Marketing of Insurance, supra,* at 177.

As a result, it will nearly always be a fact issue for the jury whether parallel refusals to provide coverage to unacceptable risks are a result of independent underwriting decisions or agreement among insurers. The risk of adverse jury determinations on the agreement issue and the consequent application of the *per se* rule will thus jeopardize continued use of uniform classifications even though approved by the states.

Rating or statistical organizations also prepare, with state authorization, standard policy forms and underwriting rules. For example, the Insurance Services Organization (ISO), a major rating and statistical organization, adopts standardized policy provisions relating to the limits, forms and scope of coverage. Like the use of standard risk classifications, standardization of coverages is necessary to facilitate the pooling of loss experience by enabling ready categorization of data. As with the use of uniform risk classifications, the use

authority to formulate rates " 'independent' of the membership." *The Pricing and Marketing of Insurance,* Report of the U.S. Department of Justice to the Task Group on Antitrust Immunities, January 1977, at 170.

of standard policy coverages (or underwriting rules), particularly by member insurers of the originating rate bureau, may be sufficient evidence upon which to base an inference of agreement. Upon a finding of agreement, the refusal to sell nonstandard coverages by insurers using uniform policy provisions would conceptually be no different from the ruling below that allegedly joint denial of "occurrence"-type coverage by insurers was a "boycott." Hence, even though regulated by the states, standardization of insurance policies may also be vulnerable to the *per se* rule.

E. The Doctrine Of *Parker v. Brown* Would Not Immunize Most Pooling Arrangements And Practices Regulated By The States

Recognizing that its decision will expose insurers to antitrust sanctions irrespective of state regulation, the Court of Appeals seems to suggest that joint refusals to provide coverage in the context of a "state-permitted structure or procedure" would be exempt under the "state action" doctrine of *Parker* v. *Brown,* 317 U.S. 341 (1943). The court's remarks ignore the fact that Congress in enacting the McCarran Act specifically rejected the approach of *Parker* v. *Brown* as insufficient to allow the states to regulate the business of insurance.[22] The court also considerably overstates the degree of protection which would be afforded in the absence of the Act.

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[22] The possibility that the *Parker* v. *Brown* exemption might protect state-regulated activities of insurers was mentioned by both the government and the Court in the decision precipitating the McCarran Act, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 562 (1944); Brief of Appellant United States, at 96-97. Both the Senate and House of Representatives were aware of this possibility but recognized that not all state regulation of insurance would fall within the *Parker* exemption. *See* H.R. Rep. No. 873, 78th Cong., 1st Sess., at 7 (1943); S. Rep. No. 1112, 78th Cong., 2d Sess., at 2, 5-7 (1944). Congress instead chose to grant an express exemption contingent only upon the *existence* of a general scheme of state regulation, in whatever form chosen and irrespective of state compulsion within the meaning of *Parker* v. *Brown*. *See also* FTC v. National Casualty Co., 357 U.S. 560, 564-5 (1958); Ohio AFL-CIO v. Insurance Rating Board, 451 F.2d 1178, 1181-2 (6th Cir. 1971).

The decision of this Court in *Cantor* v. *Detroit Edison Co.,* 428 U.S. 579 (1976), indicates that immunity for private acts regulated by the states will not be conferred when the conduct results from privately initiated proposals approved by the state even though subsequent compliance with the approved proposals is required by law. 428 U.S. at 592-95. Under this standard, most state insurance regulation, because it consists of approval or review of privately initiated proposals on such matters as rates, coverages, risk classifications and policy forms, would not be sufficient for "state action" exemption purposes. In particular, none of the activities of state-authorized insurance pools, bureaus and statistical organizations in which membership is not required would be immune even though the state specifically regulates the organization's ground rules for joint underwriting, rate-making and admission to membership. Because pool membership is voluntary, all acts undertaken by members—including those required by the state—would be discretionary in the sense that they could have been foregone if the privately initiated membership decision had not been made or if a member were able to withdraw from the pool.

Even mandatory pool participation may not exempt underwriting practices of pool members not specifically originated and compelled by the state. Fo. example,

the decision by a mandatory joint underwriting association to sell medical malpractice policies on a "claims-made" basis rather than on an "occurrence" basis, even though approved by the state insurance commissioner, would not be exempted from the Sherman Act unless state legislation specifically compels issuance *only* of the "claims-made" form of coverage."[23]

This uncertainty about the effectiveness of the *Parker* v. *Brown* doctrine in subordinating the Sherman Act to the prevalent forms of state insurance regulation was one of the very reasons why Congress chose in the McCarren Act to suspend the federal antitrust laws contingent only upon the existence, not the form or content, of state insurance regulation.

II. REMOVAL OF THE ANTITRUST EXEMPTION FROM POLICYHOLDER SUITS WILL PLACE INSURERS IN THE DILEMMA OF COMPLYING WITH CONFLICTING STATE AND FEDERAL STANDARDS

Conceding that Rhode Island regulates the business of insurance (555 F.2d at 6), the court of appeals nonetheless concluded that the federal courts were open to policyholders who allege that an inability to obtain insurance coverage resulted from an insurance company boycott. Inherent in the decision, therefore, is the potential for insurers to be caught between conflicting state regulatory standards and federal antitrust standards. The dispute in this case over the availability and type of coverage well demonstrates the problems which the decision below will create for insurers:

[23] Rhode Island and twelve other states expressly permit or do not prohibit coverage on either basis.

1. *Rate-Making:* Insureds seeking to obtain coverage in antitrust actions will probably, as did respondents, request court-ordered issuance of policies at "reasonable rates" and/or treble damages based on such rates. Judicial determination of a "fair" rate may differ from the state's determination and thus collide with the requirement in the majority of states that insurers charge only approved or filed rates.

2. *Risk Classifications and Underwriting Standards:* All states which require approval of rates also require insurers to follow approved risk classifications in determining the premiums to be paid by individual insureds. Most states additionally prohibit discrimination in the rates charged to risks in the same classification. Insureds who successfully obtain judicial relief on the grounds they were denied coverage because they were in the "wrong" risk category will expose insurers to state administrative and other sanctions.

3. *Policy Form and Coverages:* Most states now set minimum standards for policy form and content, and delegate to state insurance commissioners the power to add other conditions. The standards are administered by requiring filing and approval prior to use, or, in some states, by filing subject to later disapproval. A few states prescribe policy forms.[24] Important aspects of state policy regulation include approval of proposed coverages, prescribed coverage requirements (as in the case of mandatory automobile liability insurance) or specified coverage limitations (as in the case of some JUA malpractice policies). Federal injunctive relief

[24] *Economic Regulation of Insurance in the United States*, U.S. Department of Transportation, Automobile Insurance and Compensation Study, at 12 (June 1970).

directing the availability of coverages may thus conflict with state restrictions on the amount or type of coverage.

4. *Solvency:* A prime function of insurance regulation is to preserve the reliability of the insurance mechanism through assuring insurer solvency. State solvency regulation includes prescribed limits on the risks an insurer can select, and capital, surplus and reserve requirements. To the extent the federal courts require otherwise unavailable coverages to be written, these standards may be breached.

The dilemmas exemplified above, with the resulting impairment of effective state regulation, were, of course, precisely the type of federal-state conflicts the McCarran Act was designed to avoid.

III. CONSISTENT WITH THE POLICY OF DEFERENCE TO STATE REGULATION OF THE INSURER-INSURED RELATIONSHIP, CONGRESS INTENDED THE TERM "BOYCOTT" TO APPLY ONLY TO REFUSALS TO DEAL AMONG COMPETING INSURERS OR AGENTS

The context and legislative history of the McCarran Act indicate that the Act's boycott exception was inserted because of Congress' concern over boycott practices internal to the insurance industry and having nothing to do with state regulation or the insurer-policyholder relationship.

In *United States* v. *South-Eastern Underwriters Association,* 322 U.S. 533 (1944), this Court held for the first time that the "business of insurance" was interstate commerce and that, by its terms, the Sherman Act was applicable to this business. Rejecting an argument that application of the Sherman Act would destroy state regulation of insurance, the Court concluded that "if exceptions are to be written into the [Sherman] Act, they must come from Congress, not this Court." 322 U.S. at 561.

Congress responded to the Court's invitation by enacting the McCarran Act. As the final substantive Committee Report on S. 340, 79th Cong., 1st Sess. (1945)—the bill which, with minor modifications, was ultimately enacted—stated,

> The purpose of the bill is twofold: (1) To declare that the continued regulation and taxation by the several States of the business of insurance is in the public interest; and (2) to assure a more adequate regulation of this business in the States by suspending the application of the Sherman and Clayton Acts for approximately two sessions of the State legislatures, so that the States and the Congress may consider legislation during that period. It should be noted that this bill, by the moratorium proposed therein, does not repeal the Sherman and Clayton Acts, *but opportunity will have been granted for the States to permit agreements and contracts by insurance companies which otherwise might be in violation of the Sherman and Clayton Acts. It should be noted further that no moratorium is granted from the Sherman Act relative to agreements or acts of boycott, coercion, or intimidation.* [H.R. Rep. No. 143, 79th Cong., 1st Sess., at 3 (1945) (emphasis added).]

There is, therefore, a seeming conflict between the "opportunity" granted for the states "to permit agreements and contracts by insurance companies which otherwise might be in violation" of the antitrust laws (H.R. Rep. No. 143, *supra,* at 3), and the proviso that the Sherman Act was to remain applicable to "boycott, coercion, and intimidation." A full reading of the

legislative history of the McCarran Act, however, provides persuasive indications that the boycott exception was indended by Congress to prohibit immunity only for the type of unregulated exclusionary agreements which were the focus of the *South-Eastern Underwriters* case.

The government charges in *South-Eastern Underwriters* were basically that the defendants had fixed the prices of fire insurance and agents' commissions through their rating bureau, and had engaged in a boycott of non-members of the bureau in order to effectuate the price-fixing scheme.[25] The boycott aspect of the

[25] The United States more specifically characterized the allegations as follows:

> Each count charges that the conspiracy consisted of agreements among appellees to sell insurance and to pay commissions to agents at rates fixed by the Association, and to withhold reinsurance facilities from, and prevent access to such facilities, by non-members of the Association (R. 11, 13). It is further charged that appellees have threatened to refuse and actually refused to deal with any agency which represents companies not members of the Association, have agreed to disparage and have disparaged the services and facilities of such companies, and have threatened to boycott and withhold patronage from persons purchasing fire insurance from such companies (R. 11, 13-14). It is averred that appellees have agreed to maintain and have maintained inspection and rating bureaus and local boards in order to police, strengthen and further the agreements and practices described (R. 11-12, 14). [Brief of Appellant United States, at 3-4.]

The government's allegation that the bureau had refused to sell to policyholders of non-members was mentioned in this Court's opinion, 322 U.S. at 535-36, and was cited by the court of appeals below as justifying its interpretation of the boycott exception. 555 F.2d at 11. Seen in the context of the government's other boycott allegations, however, it becomes clear that the refusal to deal with policyholders was actually directed at non-bureau companies and their agents, as were the other practices employed by the defendants. The government's allegation thus comports with the normal usage of the term boycott. Respondents have not similarly alleged that petitioners' conduct was directed at competing insurers.

case involved a network of highly restrictive rules which had been developed by insurance companies to cartelize the industry. These rules were directed exclusively at other members of the industry and were not regulated by the states. Chief among them were the reinsurance rule, that members of the rate bureau could not grant reinsurance to non-member companies, and the separation rule, that an agent of a member company could not represent a non-member company.[26]

As the court of appeals concedes (555 F.2d at 12), "the vice of insurance self-government outside the law" typified in *South-Eastern Underwriters* was the major concern of Congress in deciding upon the scope

[26] Other restrictive intra-industry rules prevalent prior to 1944 included: (1) the single counter rule, that a company could have only one agent in an area; (2) the limitation of agency rule, that a company could have only an agreed number of agents in an area; (3) the "in-or-out" rule, that a member agent could not represent a company unless all its local agents were members; (4) the territorial limitation rule, that certain agents could write business only in certain parts of a territory; (5) the non-deviation rule, that a member agent could not represent companies selling insurance at "cut-rates"; (6) the "mutual" rule, that a member agent could not represent non-stock companies; and (7) the "direct writer" rule, that a member agent could not represent companies that also sell insurance directly to the insured. Subsequent to *South-Eastern Underwriters*, rating bureaus and other insurer associations dropped these rules. Agents' associations, however, in some cases continued their use, resulting in a series of government civil actions in the late 1950's and early 1960's. *See* United States v. New Orleans Ins. Exch., 148 F. Supp. 915 (E.D. La.), *aff'd per curiam*, 355 U.S. 22 (1957); United States v. Insurance Board of Cleveland, 144 F. Supp. 685 (N.D. Ohio 1956), 188 F. Supp. 949 (N.D. Ohio 1960); United States v. Cincinnati Ins. Bd., 1963 CCH Trade Cas. ¶ 70,945 (S.D. Ohio 1963) (consent decree); United States v. Baton Rouge Ins. Exch., 1958 CCH Trade Cas. ¶ 69,068 (E.D. La. 1958) (consent decree).

of the antitrust immunity to be granted to the insurance industry.

Senator O'Mahoney, who was the principal interrogator throughout the hearings on the McCarran Act and one of three Senators on the conference committee which drafted the boycott exception, consistently expressed antagonism to the exclusionary practices of the insurance industry.[27] In the final Senate debates, he cited extensively, as he had earlier done in the hearings, from certain "rules and regulations" of the Insurance Executives Association, characterizing them as dictating:

> . . . who should and who should not engage in the insurance business, what commission an agent should receive or should not receive, who could have desk room in the office of the representative of an insurance company and how the business should be governed. . . . [91 Cong. Rec. 1485 (1945).]

He stated his view that the Association's rules and regulations were designed "*to coerce, intimidate, and boycott its own members* and compel them to obey the rules and regulations *the association itself prescribed*" and constituted an "agreement to coerce and intimidate *persons engaged in the insurance business.*" 91 Cong. Rec. 1486 (1945) (emphasis added).

Like Senator O'Mahoney's condemnation of the cartel-like rules imposed by insurer associations, the testimony before Congress which prompted the enactment of the boycott exception all dealt with claimed acts of boycott, coercion or intimidation by members of the in-

[27] *See, e.g.*, S. Rep. No. 1112, Part II ("Minority Views"), 78th Cong., 2nd Sess., at 2-3, 4-5 (1944).

surance industry directed against other members of the insurance industry. Attorney General Biddle, for example, condemned the coercive practices used to enforce bureau rates:

> The principal instruments utilized to compel adherence to private rate-fixing agreements are reinsurance and "separation." The former is used to coerce the companies directly, the latter to coerce their agents, and through them the companies themselves. Simply stated, "separation" is a type of discipline. It means that if an agent for one or more board companies undertakes the representation either of an independent stock company or of a mutual company, all the board companies acting together immediately withdraw their business from his office. [Joint Hearing on S. 1362, H.R. 3269 and H.R. 3270 Before the Subcommittees of the Committees on the Judiciary, 78th Cong., 1st Sess. (*"Joint Hearing"*), at 48 (1943-44).]

These, of course, were the very acts of "boycott, coercion and intimidation" alleged in the *South-Eastern Underwriters* indictment itself.

Senator O'Mahoney complained of the restrictive rules and regulations of the Interstate Insurance Board which required *members* to deal only with *members* in accepting reinsurance. *Joint Hearing,* at 310. An attorney for a group of insurance brokers in Chicago, Illinois testified as to his representation of his clients in a suit against the Chicago Board of Underwriters which contained similar allegations of restrictive practices by insurance industry members against other insurance industry members. *Joint Hearing,* at 366-90. Congressman Celler, who voted against the passage of the McCarren Act (91 Cong. Rec. 1094 (1945)), was concerned that § 3(b) of the Act contain language pro-

scribing any "agreement" to boycott, coerce or intimidate because he wanted to make sure that small insurance companies or agents would not be boycotted by others in the industry. 91 Cong. Rec. 1087-88 (1945).[28]

Senator O'Mahoney also emphasized that "private combinations and groups through private rules and regulations under which *persons engaged in the insurance industry* could be tried and convicted *for the violation of private law*" would "be absolutely outlawed" by the conference report's amendment of § 3(b) to proscribe "agreements" to boycott, intimidate or coerce. 91 Cong. Rec. 1483 (1945) (emphasis added); *see also* 91 Cong. Rec. 1485 (1945) (remarks of Senator O'Mahoney) (the conference report "outlaws completely" attempts by private groups to enforce "regulations for the insurance business.")

The Court of Appeals does not actually contest the view that the practices cited by Senator O'Mahoney and others were the reason for enactment of the boycott exception. Rather, essentially because of the abbreviated nature of the debates over the Act, it concludes that the exception was not "limited" to such intra-industry conduct and could thus also encompass conduct between insurers and their policyholders. 555 F.2d at 12. In adopting that construction, however, the

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[28] Senator O'Mahoney explained the effect and purpose of the "agreement" prohibition subsequently included in § 3(b) by the Conference Committee as follows:

> [A]ny attempt by a small group of insurance companies to enter into an agreement by which *they would penalize any person or any business which was attempting to do business in the insurance field in a way that was disapproved by them,* would be absolutely prohibited by this provision. [91 Cong. Rec. 1480 (1945) (emphasis added).]

Court has allowed the exception to swallow up the whole and render nugatory the fundamental purpose of the McCarren Act "to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 459 (1969).

CONCLUSION

In the form finally enacted, the McCarren Act was compromise legislation, in that it did not provide insurers voluntarily acting in concert with total immunity from the federal antitrust laws. The basic concept of the Act was that concerted action would be sanctioned only when regulated by the states. The judgment of Congress underlying this concept was that the states were better equipped than the federal government to regulate insurance because of their proximity to local problems and because of their existing experience and expertise in regulating the industry.[29]

The major problems in insurance regulation are those connected to the relationship between insurer and insured, including the availability of coverage, the extent and price of coverage and the handling of claims. These problems tend to depend on local conditions, most amenable to decentralized state regulation. They also involve the reconciliation of competing policies:

> Simultaneous realization of the goals of insurer solvency and market availability has presented a particularly difficult dilemma for regulators. Rate levels deemed reasonable from the public's view-

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[29] *See, e.g.*, 91 Cong. Rec. 1087 (1945); 90 Cong. Rec. 6532 (1944).

> point have not always been accepted as adequate to ensure continued willingness of insurers to participate widely in the market, particularly when loss experience fluctuates widely and unpredictably or trends upward. Consequently, regulators have often come to view their task as one of balancing basically conflicting objectives. [*Economic Regulation of Insurance in the United States,* U.S. Department of Transportation, Auto Insurance and Compensation Study, at 2 (June 1970).]

The varied and innovative responses of the states to the medical malpractice crisis are indicative of the flexibility of state regulation in resolving the interconnected problems of making insurance available at reasonable rates while also preserving the reliability and solvency of insurers.

It is difficult to envision federal courts doing as able a job of overseeing the underwriting process, evaluating the different mechanisms for availability and balancing the objectives of solvency and fair rates. Yet the unspoken premise of the court of appeals' decision is that federal courts are now to determine, through application of broad antitrust standards not specifically tailored to the business of insurance, whether a failure to provide policies or coverages for certain risks is justified. This is not a task for which the judiciary is suited, and is certainly not one Congress intended the courts to assume.

To prevent this judicial reallocation of responsibilities between the states and the federal government, specifically rejected by Congress in the McCarran Act, the decision below should be reversed.

Respectfully submitted,

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